Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MICHAEL TSCHICKARDT MD
5734 SPOHN DRIVE
CORPUS CHRISTI TEXAS 78414

Respondent Name
CITY OF CORPUS CHRISTI

Carrier's Austin Representative Box
Box Number 29

MFDR Tracking Number
M4-06-2515-01

MFDR Date Received
December 8, 2005

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary taken from the table of disputed services: "Pre-authorization was obtained prior to services rendered. According to TWCC Fast Facts, if pre-approval was obtained for a compensable injury, approval guarantees payment (see Fast Facts attached)."

Amount in Dispute: $1,303.10

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The insurance carrier did not respond to the DWC060 request.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 15, 2004 and December 20, 2004	Outpatient Interlaminar Epidural at L5-S1 with Fluro Sedation	$1,303.10	$389.40

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute resolution for which the dispute resolution request was filed on or after January 1, 2003.
2. 28 Texas Administrative Code §134.202 sets out the fee guideline for professional medical services provided on or after September 1, 2002.
3. 28 Texas Administrative Code §134.600, sets out the preauthorization guidelines.
4. Division rule at 28 TAC §134.1, effective May 16, 2002, requires that services not identified in a fee guideline shall be reimbursed at fair and reasonable rates.

5. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated February 16, 2005

- W11 – 862 – Entitlement to benefits

Explanation of benefits dated May 12, 2005
- W11 – 862 – Entitlement to benefits

Issues

1. Does the dispute contain unresolved compensability, extent of injury or liability (CEL) issues?
2. Did the requestor request Medical Fee Dispute Resolution (MDR) for date of service October 15, 2004 within the one year filing deadline?
3. Did the requestor bill for bundled codes?
4. Did the requestor obtain preauthorization for the disputed charges?
5. Did the requestor submit documentation to support fair and reasonable reimbursement for the unvalued codes?
6. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §133.307(e)(2)(D), "(e) Request (General). All provider and carrier requests for medical dispute resolution shall be made in the form, format, and manner prescribed by the commission. (Requests for medical dispute resolution on medical fee disputes involving an employee's request for reimbursement of medical expenses are governed by subsection (f) of this section). (2) Each copy of the request shall be legible, include only a single copy of each document, and shall include: (D) if the carrier has raised a dispute pertaining to liability for the claim, compensability, or extent of injury, in accordance with §124.2 of this title (relating to Carrier Reporting and Notification Requirements), the request for an IRO will be held in abeyance until those disputes have been resolved by a final decision of the commission." Review of the submitted documentation finds:
   - Review of the explanation of benefits dated February 16, 2005 and May 12, 2005 denied dates of service October 15, 2004 and December 20, 2004 with denial reasons "W11 – 862 – Entitlement to benefits."
   - The insurance carrier did not respond to the DWC060 to support the denial of entitlement to benefits.
   - Review of the preauthorization letter does not indicate that an entitlement issue is pending or has been raised by the insurance.
   - The division is unable to determine for what reason the insurance carrier is denying entitlement to benefits. The insurance carrier's denial is unsupported.
   - The MDR will therefore review the disputed charges according to the applicable rules.
2. Per 28 Texas Administrative Code §133.307 "(d) Timeliness. A person or entity who fails to timely file a request waives the right to medical dispute resolution. The commission shall deem a request to be filed on the date the division receives the initial request, and timeliness shall be determined as follows: (1) A request for medical dispute resolution on a carrier denial or reduction, of a medical bill pursuant to §133.304 of this title (relating to Medical Payments and Denials) or an employee reimbursement request shall be considered timely if it is filed with the carrier and the division no later than one (1) year after the date(s) of service in dispute." Review of the submitted documentation finds:
   - The requestor disputes date of service October 15, 2004.
   - The MDR received the dispute on December 8, 2005.
   - Date of service October 15, 2004 was filed after the one year filing deadline and is therefore not eligible for review.
   - Date of service December 8, 2004 was filed timely (within the one year filing deadline) and will be reviewed by MDR.
3. Per 28 Texas Administrative Code §134.202 "(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided with any additions or exceptions in this section." CCI edits were run to determine if edit conflicts exists for date of service December 8, 2004. Review of the CCI edits finds:
   - No CCI edit conflicts were identified.

4. Per 28 Texas Administrative Code §134.600, preauthorization was obtained from FARA Healthcare

Management. Review of the preauthorization letter dated October 6, 2004 reveals that the requestor obtained preauthorization for Interlaminar Epidural Steroid Injection at the L5-S1 level with Fluro & Sedation. Preauthorization was approved under certification number 091089201. The requestor rendered and billed Interlaminar Epidural Steroid Injection at the L5-S1 level with Fluro & Sedation.

5. Per 28 Texas Administrative Code §134.202 "(c) To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications: (1) for service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Surgery, Radiology, and Pathology the conversion factor to be used for determining reimbursement in the Texas workers' compensation system is the effective conversion factor adopted by CMS multiplied by 125%. For Anesthesiology services, the same conversion factor shall be used. (2) for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L: (A) 125% of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule. (B) if the code has no published Medicare rate, 125% of the published Texas Medicaid Fee Schedule Durable Medical Equipment/Medical Supplies Report J, for HCPCS; or (C) if neither paragraph (2)(A) nor (2)(B) of this section apply, then as calculated according to paragraph (6) of this subsection.
   - CPT code 99141 is defined as "Sedation with or without analgesia (conscious sedation); intravenous, intramuscular or inhalation."
   - Review of the Medicare Fee schedule does not value CPT code 99141; therefore reimbursement is subject to Rule 134.1.

   Per 28 Texas Administrative Code §134.202 "(c) To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications: (6) for products and services for which CMS or the commission does not establish a relative value unit and/or a payment amount the carrier shall assign a relative value, which may be based on nationally recognized published relative value studies, published commission medical dispute decisions, and values assigned for services involving similar work and resource commitments."

   Division rule at 28 TAC §134.1 requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."

   Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

   Former 28 Texas Administrative Code §133.307(g)(3)(D), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:

   - The requestor billed CPT code 99141 on December 20, 2004.
   - The CPT code indicated above does not have a Medicare assigned value.
   - Division rule at 28 TAC §134.1, effective May 16, 2002 requires that services not identified in a fee guideline shall be reimbursed at fair and reasonable rates.
   - The requestor did not provide documentation to demonstrate how it determined its usual and customary charges for CPT code 99141.
   - Documentation of the comparison of charges to other carriers was not presented for review.
   - Documentation of the amount of reimbursement received for these same or similar services was not presented for review.
   - The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.

   The requestor did not support that the requested alternative reimbursement methodology would satisfy the requirements of 28 Texas Administrative Code §134.1.

6. Per 28 Texas Administrative Code §134.202 "(c) To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications: (1) for service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Surgery, Radiology, and Pathology the conversion factor to be used for determining reimbursement in the Texas workers' compensation system is the effective conversion factor adopted by CMS multiplied by 125%... (2) for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L: (A) 125% of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule...." Review of the submitted documentation finds that:

   - The requestor billed and documented procedure codes 62311, J1040, J2250 and 76005 rendered on December 20, 2004.
   - The CMS-1500 identifies that the services were provided in an office setting (place of service code 11). Reimbursement is therefore recommended at the non-facility rate.
   - CPT code 62311: The Medicare rate is $223.13 x 125% = MAR $278.91. This amount is recommended.
   - CPT code 76005-WP, modifier WP was appended to identify that the requestor provided both the professional and technical component. The Medicare rate is $75.00 x 125% = MAR $93.75. This amount is recommended.
   - HCPC code J1040: The Medicare rate is $8.27 x 125% = MAR $10.34. This amount is recommended.
   - HCPC code J2250 x 4: The Medicare rate is $1.28 x 125% = MAR $1.60 x 4 = $6.40. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $389.40.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $389.40 plus applicable accrued interest per 28 Texas Administrative Code use §134.803 for dates of service prior to 5/2/06, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	March 19, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.